PATIENT INFORMATION

First Name (legal)	Middle Initial	Last Name	Suffix		Date of Birth	Age	Sex	Marital Status

Street Address (including apt. or suite number)	Have you ever been treated by our providers before? YES NO
City, State, Zip	May we leave information about your diagnosis and treatment on your answering machine? **(Please Initial)**
Patient Employer	Yes _____ No _____
Patient Email Address	How may we contact you? (**Please initial all we may use**)
Phone Numbers	Home Phone: _____ Cell: _____ Work Phone: _____ Email: _____ Other (be specific): _____
Name of Spouse or Significant Other Phone Number	Name of Emergency Contact (friend or relative not living with you) RELATIONSHIP Phone Number

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance Company		Insurance Company	
Policy Holder's Name		Policy Holder's Name	
Patient's Relationship to Policy Holder		Patient's Relationship to Policy Holder	
	Policy Holder's Date of Birth		Policy Holder's Date of Birth
Policy Number	Group Number	Policy Number	Group Number

RACE*	**ETHNICITY***
❑ American Indian or Alaska Native	❑ Hispanic or Latino
❑ Asian	❑ Non Hispanic or Latino
❑ Black or African American	❑ Declined
❑ Native Hawaiian or Other Pacific Islander	
❑ White	
❑ Declined	** Race, Ethnicity, and Language are questions required by the federal government (ARRA).*

PREFERRED LANGUAGE*

❑ **English** ❑ **Other:** _____

TERTIARY INSURANCE	
Insurance Company	Policy Holder's Name
DOCTORS	
Doctor	
Family Doctor	
Referring Doctor	

IF INSURANCE PAYMENT OR LEGAL SETTLEMENT IS **INVOLVED IN THE REASON FOR WHICH I AM BEING SEEN, I UNDERSTAND THAT MY RELATIONSHIP IS WITH THE PHYSICIANS AND STAFF OF THIS OFFICE, AND THAT I AM PERSONALLY RESPONSIBLE FOR THE AMOUNT NOT COVERED BY INSURANCE FOR SERVICES RENDERED. I** hereby authorize Iowa Digestive Disease Center to release to my insurance company or its representatives, any information including the diagnosis and the records of any treatment of examination rendered to me during the period of such medical or surgical care. I also authorize and request my insurance company to pay directly to the above named doctor the amount due me in my pending claim for basic medical and/or surgical treatment or services, by reason of such treatment or services rendered to me. In addition, I have received a copy of the Notice of Privacy Practices Brochure for the Iowa Digestive Disease Center.

Signed: _____ Initials: _____ Date: _____
(PATIENT OR AUTHORIZED PERSON)

Relationship if not patient: _____ Initials: _____

Patient Consent For Review For Medical Research. Iowa Digestive Disease Center supports the advancement in medical research through participation in clinical medical research studies. IDDC is hereby requesting your permission to have healthcare professionals review your medical records to see if you may qualify for a study. It will be completely confidential. Please initial your choice below:

_____ YES I give permission for my medical records to be reviewed for medical research purposes.
_____ NO I do NOT give permission for my medical records to be reviewed for medical research purposes.